	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMPI	
			B. WIN			10/10	/2014
	PROVIDER OR SUPPLIEF AT EAGLE CREEK			5045 W	ADDRESS, CITY, STATE, ZIP CODE 52ND ST APOLIS, IN 46254		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
	This visit was for Licensure Surve	or a State Residential y.	R00	0000			
	Survey dates: O	ctober 9 and 10, 2014.					
	Facility Number Provider Numbe AIM Number: N	er: 003915					
	Survey Team: Tracina Moody, Lora Brettnache (October 9, 2014 Kewanna Gordo	r, RN 4)					
	Census bed type Residential: 55 Total: 55	:					
	Census payor ty Medicaid: 48 Other: 7 Total: 55	pe:					
	Sample: 7						
	accordance with Quality review v	ings were cited in 410 IAC 16.2-5.					
	Alley RN on Oc	tober 14, 2014.					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 8 State Form Event ID: FCTR11 Facility ID: 003915 If continuation sheet

AND PLAN	OF CORRECTION PROVIDER OR SUPPLIER AT EAGLE CREEK SUMMARY S' (EACH DEFICIEN		5045 V	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE V 52ND ST VAPOLIS, IN 46254 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X3) DATE SURVEY COMPLETED 10/10/2014 (X5) COMPLETION DATE
R000272	(e) All food shall be appropriate temperature temperature. The the potential to a who consumed fixitchen. Findings included During an observed take the food being properation of the bone in/not processed to the bone in/not processed to the chicken temperature. The the chicken from the on the steam tabe during the noon the steam tabe during an interval.	pal Services - Deficiency e served at a safe and erature. ation and interview, the ensure poultry was and appropriate is deficient practice had affect 55 of 55 residents food from the facility's exact and placed it le for service to residents	R000272	It is the intent of this facility to ensure all food be served at safe and appropriate temperature. 1. All residents were obse for adverse effects related to deficient practice. No conce were noted by any resident. Current facility policies and procedures have been review and updated as necessary to address this deficient practice. The current policy related to Infection Control and Food Preparation now contains an addendum which specifies so internal temperatures for corresponding food categorie Please refer to the current powith its addendum included a attachment to this plan of correction. All staff will be educated on all updated faci policies and procedures and be trained oncorrect practice. 2. All residents have the potential to be affected by the deficient practice. Current facilities and procedures have been reviewed and updated necessary to address this deficient practice. The curre policy related to Infection Co and Food Preparation now	rved othis rns wed othee. afe es. olicy as an lity will es. is acility e as

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/10/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		V 52ND ST	
BLOOM .	AT EAGLE CREEK			NAPOLIS, IN 46254	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		to at least "150 degrees		contains an addendum	
	should be good.	"		which specifies safe internatemperatures for correspond	
				food categories. Please refe	•
	During an interv	view on 10/9/14 at 12:45		the current policy with its	
	_	tive Director (ED)		addendum included as an	
	1 ^	en should be cooked "a		attachment to this plan of	
				correction. All staff will be	
		in 160 degrees F. The ED		educated on all updatedfaci	
		cility did not have a		policies and procedures and	
	policy which inc			be trained on correct practic	
	temperature foo	ds should be cooked		Current facility policies procedures have been revie	
	however, the fac	cility followed the Retail		and updated as necessary t	
	Food Establishn	nent Sanitation		address this deficient practic	
	Guidelines which	ch indicated poultry		The current policy related to	
		ed to "at least 165		Infection Control and Food	
		d to at least 103		Preparation now contains a	n
	degrees."			addendum which specifies s	safe
				internal temperatures for	
		Establishment Sanitation		corresponding food categori	
	Guidelines indic	cated, "Minimum		Please refer to the current p	
	cooking Temper	ratures and Holding		with its addendum included attachment to this plan of	as an
	Times at Specifi	ied Temperature 165 F		correction. All staff will be	
		15 seconds-Poultry and		educated on all updated fac	ility
	foods containing	•		policies and procedures and	
	100us containing	5 pouru y		be trained on correct practic	
				For quality assurance purpo	
				and to ensure that all food is	
				served at safe andappropria	
				temperatures, the administra	
				or his designee will observe	
				temperatures being taken da for one week, then once we	
				for one month, and monthly	Civily
				thereafter and at random for	up to
				one year. The administrator	
				his designee will ensure tha	
				measured food temperature	s
				coincide with facility policy a	is well
				as with current state	
	Ī		i	Î.	l I

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/10/2014
	PROVIDER OR SUPPLIER		5045 W	ADDRESS, CITY, STATE, ZIP CODE 7 52ND ST APOLIS, IN 46254	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				recommended food temperatures. All observation will be maintained. (*daily du normal business days and excluding holidays and weekends) 4 For quality assurance purposes and to ensure that a food is served at safe andappropriate temperatures, administrator or his designee observe food temperatures be taken daily* for one week, the once weekly for one month, a monthly thereafter and at rand for up to one year. The administrator or his designee ensure that the measured foo temperatures coincide with far policy as well aswith current s recommended food temperatures. All observation will be maintained. (*daily du normal business days and excluding holidays and weekends) 5. All staff will be educated correct practices and all updaf facility policies and procedure October 24, 2014.	ring III the will eing n nd dom will d cility tate as ring
R000273	(f) All food prepara (excluding areas in maintained in acco	nal Services - Deficiency ation and serving areas n residents ' units) are ordance with state and d safe food handling			
	Based on observ	ation and interview, the ensure outer openings in	R000273	It is the intent of this facility to ensure all food preparation ar serving areas (excluding area residents' units) are maintaine	s in

State Form Event ID: FCTR11 Facility ID: 003915 If continuation sheet Page 4 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	7	00	COMPL	ETED	
			B. WING	,		10/10/	2014
				REET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				52ND ST		
	AT EAGLE CREEK				APOLIS, IN 46254		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	G			DATE
	the kitchen were	protected against the			accordance with state and loca		
	entry of insects a	and rodents and failed to			sanitation and safe food handle	ing	
	ensure the kitche	en thermometer was			standards. 1. All residents were observ	vod.	
	cleaned properly	to prevent			for adverse effects related to t		
		uring food temperature			deficient practice. No concern		
		ese deficient practices			were noted by any resident. T		
	_	_			kitchen and dining areas were		
	_	to affect 55 of 55			observed for evidence of pests		
		nsumed food from the			rodents, and other sources of		
	facility kitchen.				contamination in food storage	1	
					areas. No concerns were note Current facility policies and	ea.	
	Findings include	:			procedures have been reviewe	ed he	
					and updated as necessary to	cu	
	During an observ	vation of the noon meal			address this deficient practice.		
	_	on 10/9/14 beginning at			The current dining policy relate	ed	
		ending at 11:55 a.m., a			to Infection Control and		
		_			Environment now contains		
		en was observed propped			additional item numbers included the fall suriant A \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
	_	. The door lacked a			the following: A.) Item "3" now states, "utensils will be sanitized		
		r method to prevent the			using the approved chemical	c u	
	entry of rodents	or insects.			sanitizing agent." "Utensils"		
					include but are not limited to fo	ood	
	During an observ	vation on 10/9/14 at			thermometers; "sanitizing age	nt"	
	11:35 a.m., the D	Dietary Manager (DM)			would include but is not limited		
		king food temperatures of			the use of an alcohol swab be	fore	
		repared for the noon			and after each temperature is	too.	
		ook the temperature of			obtained. B.) Item "8" now sta "Outside doors are never left	ites,	
		-			open" See the current policy	V	
		reviously cooked			with its revisions included as a		
		ermometer indicated the			attachment to this plan of		
	_	ture was 160 degrees.			correction for further detail. Al	II	
	The DM remove	d the thermometer from			staff will be educated on all		
	the chicken and	wiped it off with a dry			updated facility policies and		
	paper towel. The	e DM then inserted the			procedures and will be trained	on	
		the green beans. The			correct practices. 2. All residents have the		
		e thermometer from the			potential to be affected by this		
					deficient practice. Current fac		
	green beans and	wiped it off with a dry			admoiding praduce. Our crit lac	y	

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/10/2014
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	R		/ 52ND ST	
BLOOM.	AT EAGLE CREEK			IAPOLIS, IN 46254	
	•			J213, 111 1020 1	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	ON (X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		2.112
	paper towel. Th	e DM then inserted the		policies and procedures ha	
	thermometer into	o the fried potatoes.		been reviewed and updated necessary to address this	u as
	After he obtaine	d a temperature of the		deficient practice. The curre	ent
	fried potatoes he	e removed the		dining policy related to Infe	
	_	iped it off with a dry		Control and Environment n	
	· ·	the thermometer back		contains additional item nu	
				including the following: A.)	
	[nen placed it on the		"3" now states, "utensils wil	
	counter.			sanitized using the approve	ed
				chemical sanitizing	
	During an interv	view on 10/9/14 at 11:40		agent." "Utensils" include b not limited to food thermom	
	a.m., the DM wa	as queried regarding the		"sanitizing agent" would inc	· · · · · · · · · · · · · · · · · · ·
	proper sanitation			but is not limited to the use	
		tween food temperatures.		alcohol swab before and af	
		could use a dry paper		each temperature is obtaine	
				Item "8" now states, "Outsid	
	tower or a "rag"	to clean the thermometer.		doors are never left open	" See
				the current policy with its	
	During an interv	view on 10/9/14 at 12:45		revisions included as an	
	p.m., the Execut	rive Director (ED)		attachment to this plan of	A.II
	indicated the fac	cility did not have a		correction for further detail. staff will be educated on all	
	policy which inc	dicated the kitchen door		updated facility policies and	
	1 ^ -	or how the thermometer		procedures and will be train	
		zed. The ED indicated		correct practices.	
				Current facility policies	s and
		should not be propped		procedures have been revi	ewed
		kitchen staff had		and updated as necessary	
	"sanitizer wipes"	" to clean the		address this deficient pract	
	thermometer and	d they should not be		The current dining policy re	elated
	using a dry pape	er towel or a rag.		to Infection Control and Environment now contains	
		-		additional item numbers inc	cluding
				the following: A.) Item "3" n	
				states, "utensils will be san	
				using the approved chemic	
				sanitizing agent." "Utensils'	
				include but are not limited t	o food
				thermometers; "sanitizing a	_
				would include but is not lim	ited to
1	i e		I	i .	

State Form Event ID: FCTR11 Facility ID: 003915 If continuation sheet Page 6 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2014 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILI B. WING	DING	00	COMPL 10/10/	ETED
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-	
BLOOM A	AT EAGLE CREEK				52ND ST APOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					the use of an alcohol swab bet and after each temperature is obtained. B.) Item "8" now state "Outside doors are never left open" See the current policy with its revisions included as a attachment to this plan of correction for further detail. Al staff will be educated on all updated facility policies and procedures and willbe trained correct practices. For quality assurance purposes, the administrator or his designee we conduct observation rounds in kitchen daily* for one week, the once weekly for one month, armonthly thereafter and at rand for up to one year. The administrator or his designee wobserve to ensure outside doo are never left open and will also observe for evidence of pests, rodents, and other sources of contamination in food storage areas. If necessary, a pest control program will be implemented at the discretion the administrator. Additionally for quality assurance purposes the administrator or his design will conduct observation round the kitchen daily* for one week then once weekly for one mon and monthly thereafter and at random for up to one year. The administrator or his designee wobserve that when food temperatures are being taken, that proper sanitation technique are being utilized by kitchen stall observations will be	tes, / in I on will the en hd om will ors of / s, ee in k, th, e will hes	

State Form Event ID: FCTR11 Facility ID: 003915 If continuation sheet Page 7 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN (T OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIE	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING STREET	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 10/10/2014
	AT EAGLE CREEP			V 52ND ST NAPOLIS, IN 46254	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				maintained. 4. For quality assurance purposes, the administrator of designee will conduct observer ounds in the kitchen daily* for one week, then once weekly one month, and monthly thereafter and at random for one year. The administrator of designee will observe to ensure outside doors are never left of and will also observe for evide of pests, rodents, and other sources of contamination in fistorage areas. If necessary, pest control program will be implemented at the discretion the administrator. Additional for quality assurance purpose the administrator or his design will conduct observation round the kitchen daily* for one weekly for one modern and monthly thereafter and a random for up to one year. The administrator or his designee observe that when food temperatures are being taken that proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique are being utilized by kitchen and the proper sanitation technique and procedure correct practices and all updated acility policies and procedure october 24, 2014.	or his ation or for up to r his ure upen ence ood a n of ated on the will n, ues staff.

State Form Event ID: FCTR11 Facility ID: 003915 If continuation sheet Page 8 of 8